Fairfax County Public Schools

Plan Year 2004
Group #3044

Kaiser Foundation Health Plan of the
Mid-Atlantic States, Inc.
2101 East Jefferson Street, Rockville,
Maryland 20849

Benefit Summary

VA/HMO
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The following is a general description of the benefits, services, exclusions, and limitations provided under Kaiser Permanente's health benefit plan. This is only a summary and does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your employer's Group Agreement Face Sheet, Group Evidence of Coverage(VALG-EOC-SIGNATURE or VALG-EOC-SELECT), Group Agreement, and applicable Riders. The Evidence of Coverage is the legal binding document between Health Plan and its members. In the event of ambiguity, or a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage shall control. With the exception of Emergency Services and Out-of-Area Urgent Care Services, all covered in-plan services must be provided by, or authorized and arranged by your Plan Primary Care Physician. Gynecology, behavioral health, substance abuse, and optometry services may be obtained without a referral from your Primary Care Physician; however, they must be provided by a Plan Physician or other Plan Provider.

Accidental Dental Injuries	**Copayment**
Accidental dental injury services	No Charge for primary care visits for children up to age 5; all others $10 per visit
Allergy Evaluation, Testing and Treatment	**Copayment**
Allergy evaluation, testing and treatment	No Charge for primary care visits for children up to age 5; all others $10 per visit

Behavioral Health	Copayment
Inpatient mental health and substance abuse services provided through the Plan's managed care system	$100 per Member per admission
Outpatient mental health and substance abuse services provided through the Plan's managed care system	You pay $10 per visit
Chemotherapy and Radiation Therapy	**Copayment**
Chemotherapy and radiation therapy	No Charge for primary care visits for children up to age 5; all others $10 per visit
Durable Medical Equipment	**Copayment**
Durable medical equipment	Full DME w/Prosthetics & Orthotics (Rider): No Charge
Oxygen and Equipment	**Copayment**
Oxygen and equipment	You pay 20% of non-member rates for 1st three months;50% of UCR each month thereafter
Asthma Equipment	**Copayment**
Spacers	$5 per item
Peak-Flow Meters	$10 per item
Nebulizers	$30 per item
Early Intervention Services	**Copayment**
Early intervention services. Health Plan pays up to $5,000 per contract year.	No Charge for primary care visits for children up to age 5; all others $10 per visit
Emergency Services	**Copayment**
Inside the Service Area	$50 per visit; waived if immediately admitted
Outside the Service Area	$50 per visit; waived if immediately admitted
Family Planning	**Copayment**
Outpatient family planning visits	same as office visit copay
Outpatient surgery for a tubal ligation	same as office visit copay
Outpatient surgery for a vasectomy	same as office visit copay
Interrupted pregnancy	same as office visit copay
Home Health Care	**Copayment**
Covered home health care	No Charge
Hospice Care	**Copayment**
Covered hospice care	No Charge

Hospital Services	Copayment
Covered inpatient hospital services	$100 per Member per admission
Imaging, Lab Tests, and Special Procedures	**Copayment**
Inpatient diagnostic imaging, lab tests, and special procedures	No Charge
Outpatient diagnostic imaging, lab tests, and special procedures	No Charge
Infertility Services	**Copayment**
Office visits	50% of non-member rates
Outpatient surgery	50% of non-member rates
Outpatient imaging, lab tests, and special procedures	50% of non-member rates
Hospitalization	$100 per Member per admission
Maternity Services	**Copayment**
Outpatient prenatal visits	No Charge
Outpatient postnatal visit	No Charge
Outpatient Services	**Copayment**
Primary care visits	No Charge for primary care visits for children up to age 5; all others $10 per visit
Specialty care visits	No Charge for primary care visits for children up to age 5; all others $10 per visit
Same-day outpatient surgery	No Charge for primary care visits for children up to age 5; all others $10 per visit
Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation	**Copayment**
Physical, Occupational, and Speech Therapy: Inpatient services	No Charge
Outpatient services	No Charge for primary care visits for children up to age 5; all others $10 per visit
Prosthetics	**Copayment**
Internally implanted devices	No Charge
External prosthetic devices	Full DME w/Prosthetics & Orthotics (Rider): No Charge
Skilled Nursing Facility	**Copayment**
Care in Skilled Nursing facility Up to 100 days per year	$100 per Member per admission

Urgent Care	Copayment
Inside the Service Area	No Charge for primary care visits for children up to age 5; all others $10 per visit
Outside the Service Area	No Charge for primary care visits for children up to age 5; all others $10 per visit
Vision	**Copayment**
Eye refraction exams to determine the need for vision correction and to provide prescription for eyeglasses	No Charge for primary care visits for children up to age 5; all others $10 per visit
Regular eyeglass lenses every 12 months	25% discount
An eyeglass frame every 12 months	25% discount
Medically necessary contact lenses	15% discount
Prescription	**Copayment**
Covered prescription drugs	$8 generic/$18 brand name through mail order;$10 generic/$20 brand name at a Plan Pharmacy; $16 generic/$32 brand name at a Participating Network Pharmacy
Dental	**Copayment**
Covered dental services	No Coverage

Exclusions

The following section provides you with information on what services and supplies Kaiser Permanente will not pay for regardless of whether the service is medically necessary or not. The services and supplies listed below are excluded from coverage. These exclusions apply to all services and supplies that would otherwise be covered under the plan. When a service or supply is excluded, all services and supplies related to that excluded service or supply are also excluded, even if they would otherwise be covered under this plan.

GENERAL EXCLUSIONS:

Alternative Care

Acupuncture, chiropractic, naturopathic, and therapeutic message therapy services and supplies.

Certain Exams and Services

Physical examinations and other services and supplies (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance or licensing, or (c) on court-order or required for parole or probation. This exclusion does not apply if a Plan Provider determines that the services and supplies are medically necessary.

Cosmetic Services

Plastic surgery or other cosmetic services and supplies that are intended primarily to improve your appearance and will not result in significant improvement, except for services and supplies covered under "Reconstructive Surgery" or "Prosthetics" in the "Benefits" section.

Custodial Care

Custodial care means:

- Assistance with activities of daily living, for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine.
- Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Dental Care

Except as covered under "Accidental Dental Injuries", "Cleft-Lip, Cleft-Palate or Both", and "Oral Surgery" sections of the "Benefits" section, or in your dental rider (if applicable), dental care and dental x-rays, including dental appliances, implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporal mandibular joint (TMJ) pain dysfunction syndrome.

Domiciliary Care

Care provided to an individual who is capable of caring for himself or herself, however, he or she must be maintained in a monitored environment for health maintenance and safety.

Employer Requirements

Financial responsibility for services and supplies that an employer is required by law to provide.

Experimental or Investigational Services

Except as covered under "Clinical Trials" section of the "Benefits" section, a service is experimental or investigational for a Member's condition if any of the following statements apply to it as of the time the service is or will be provided to the Member.

The service:

- can not be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
- is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
- is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:

- the Member's medical records,
- the written protocol(s) or other document(s) pursuant to which the service has been or will be provided,
- any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service,
- the files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- the published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and
- regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Health Plan consults Medical Group and then uses the criteria described above to decide if a particular service is experimental or investigational.

Government Agencies

Financial responsibility for services and supplies that a government agency is required by law to provide.

Intermediate Care

Care in an intermediate care facility.

Military Services

Services and supplies for conditions arising from military service that are reasonably available from the Veterans Administration.

Orthotics

Services and supplies for orthotics.

Prohibited Referrals

Payment of any claim, bill, or other demand or request for payment for covered services determined to be furnished as the result of a referral prohibited by law.

Routine Foot Care Services

Routine foot care services and supplies that are not medically necessary.

Services and Supplies Not Available in Our Service Area

Services and supplies not generally and customarily available in our Service Area, except when it is generally accepted medical practice in our Service Area to refer Members outside our Service Area for the service or supply.

Sexual Reassignment

Services related to sexual reassignment surgery, including sex change operations or transformation and procedures or treatments designed to alter physical characteristics.

Surrogacy

Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Travel Costs

Travel, lodging, and living expenses when authorized to seek covered services outside the Service Area.

Travel Immunizations

Services, supplies, and drugs for the sole purpose of foreign travel.

Whole Blood and Compact Red Blood Cells

Except as covered under the "Blood Products and Derivatives" section of the "Benefits" section, we do not cover the cost of whole blood or compact red blood cells. We do, however, cover the administration.

BENEFIT SPECIFIC EXCLUSIONS:

Exclusions specific to benefits that have not been described in this summary can be found in the Evidence of Coverage.

Accidental Dental Injury Exclusion(s)

- Services provided by Non-Plan Providers.
- Services provided after 12 months from the date the injury occurred.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

Behavioral Health Exclusion(s)

- Services and supplies in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse, or drug addiction except as described above.
- Services and supplies for Members who, in the opinion of the Plan Provider, are seeking services and supplies for other than therapeutic purposes.
- Psychological testing for ability, aptitude, intelligence, or interest.
- Services and supplies on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
- Evaluations that are primarily for legal or administrative purposes are not medically indicated.

Durable Medical Equipment Exclusion(s)

- Oxygen tents.
- Equipment generally used for comfort or convenience that is not primarily medical in nature (e.g., bed boards, bathtub lifts, adjust-a-beds, telephone arms, air conditioners, and humidifiers).
- Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Member's condition and in order for the Member to operate the equipment.
- Disposable supplies, exercise and hygiene equipment, experimental or research equipment, and devises not medical in nature such as sauna baths, elevators, or modifications to the home or automobile. This exclusion does not apply to disposable diabetes and/or supplies.

Family Planning Exclusion(s)

- Reversal of surgically induced sterility

Home Health Exclusion(s)

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section of this EOC).
- Routine administration of oral medications, eye drops, ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker services and supplies.
- Care that a Plan Provider may determine may be provided in a Plan Medical Office, Plan Provider's office, Plan Hospital, or Skilled Nursing Facility and we provide or offer to provide that care in one of these facilities.
- Transportation and delivery service costs of Durable Medical Equipment, Medications and Drugs, Medical Supplies, and Supplements to the home.

Infertility Exclusion(s)

- The cost of donor semen and donor eggs including retrieval of eggs.
- Storage and freezing of eggs.
- In-Vitro fertilization
- Gamete intrafallopian transfers (GIFT)
- Zygote intrafallopian transfers (ZIFT)

Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation Exclusion(s)

- Long-term rehabilitative care.

Prosthetic Exclusion(s)

- Internally implanted breast prosthetics for cosmetic purposes.
- Dental prosthetics and appliances, unless for cleft-lip, cleft palate, or both.
- External prosthetics, except for breast following a covered mastectomy.
- Wigs
- Hearing aids
- Corrective lenses and eyeglasses, except as provided under the "Vision Care" benefit of this section.
- Repair or replacement of prosthetics due to loss or misuse.
- More than one device for the same part of the body, except for replacements; spare devices or alternative use devices.
- Non-rigid supplies, such as elastic stockings.
- Electronic voice producing machines.

Skilled Nursing Exclusion(s)

- Custodial care.
- Domiciliary care.

Urgent Care Exclusion(s)

- Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

Vision Exclusion(s)

- Sunglasses without corrective lenses unless medically necessary;
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism.
- Eye exercises;
- Cosmetic contact lenses;
- All services related to contact lenses including examinations, fitting and dispensing, and follow-up visits, except as otherwise covered under this section. Any contact lenses required by the Member after the initial pair of lenses is provided by Health Plan may be purchased at a Kaiser Permanente Optical Shop on a fee-for-service basis.
- Replacement of lost or broken lenses or frames.